

**TRAUMATIC BRAIN INJURY WAIVER PROGRAM
PERSONAL ATTENDANT SERVICES WORKSHEET**

PARTICIPANT NAME: _____

Attendant Name: _____

Begin Date: _____

End Date: _____

Date M/D/Y									CONDITION OF PARTICIPANT KEY
Time Arrived									The attendant must list a Condition of Participant on the worksheet at the end of each shift worked. Excellent Good Poor* If poor, please explain in the notes section
Time Left									
Total Hours Worked									
Part./LR Initials:									
Condition of Participant									
Date M/D/Y									Supervisor Comments:
Time Arrived									
Time Left									
Total Hours Worked									
Part./LR Initials:									
Condition of Participant									

Personal Attendant Comments and Notes for the 2-week period: (notes should reflect services provided and person's response to the services)

By signing, I certify that the reported information is complete and accurate on all the pages. I understand that payment for services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under Medicaid Fraud.

Personal Attendant Signature and Date

Participant/Legal Representative Signature and Date

Supervisor Signature and Date